

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6216  
CERTIFICATE OF DEATH

06171

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Valley Lee</b>				c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Leo</b> Last <b>Bean</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1912</b>		9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Bean</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Dora Redman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-16-2202</b>		17. INFORMANT <b>Genevieve Bean Valley Lee, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420-1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastric ulcer</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 29, 1960</b> to <b>May 29, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1960</b> , and that death occurred at <b>6:41</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>P. J. Bean M. D.</b>				22b. DATE SIGNED <b>May 29, 1960</b>		22c. PHYSICIAN'S NAME (Type) <b>P. J. Bean M. D.</b>	
22d. ADDRESS <b>Great Mills, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/1/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. George's</b>		23d. LOCATION (City, town, or county) (State) <b>Valley Lee, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>				25a. REG'D BY REGISTRAR <b>JUN 2 60</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Thomas</b>	

# CERTIFICATE OF DEATH

2318

St. Mary's  
 20 years  
 Valley Ave

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6217  
CERTIFICATE OF DEATH  
06172

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakley</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Q.</b> Last <b>Bowling</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 1, 1897</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Julian Albert Bowling</b>				14. MOTHER'S MAIDEN NAME <b>Mary Emily McWilliams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>				16. SOCIAL SECURITY NO. <b>217 36 7084</b>		17. INFORMANT <b>Mrs M.E.Danos</b> Address <b>Oakley, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia</b> 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>5 yrs.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1959</b> 19 to <b>May 5</b> 1960, that (I) (we) last saw the deceased alive on <b>May 3</b> 1960, and that death occurred at <b>3AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W.D. Boyd</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>William D. Boyd M. D.</b>				22d. ADDRESS <b>Leonardtown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/7/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 10 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1917

CERTIFICATE OF DEATH

1917

CHIEF CLERK

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Pages 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
6218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06173

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>MORGANZA</b>				c. LENGTH OF STAY IN b <b>X</b> <b>Morganza</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>John Alexander Burroughs</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1904</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Alexander Burroughs</b>				14. MOTHER'S MAIDEN NAME <b>Subie Harrietta Stewart</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs Sadie Burroughs Morganza. Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUN SHOT</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self with shot gun (in neck)</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11-15 5-6 19 60</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>	20f. (City or town) <b>MORGANZA</b>	(County) <b>ST Mary</b>	(State) <b>MD</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W.D. Boyd</b>		EXAMINER'S NAME (Type) <b>William D. Boyd</b>		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5/9/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b>		22d. LOCATION (City, town, or country) (State) <b>Morganza, Maryland</b>		
23. FUNERAL DIRECTOR ADDRESS <b>W. Clarke Mattingley Leonardtown, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	







1-1-1  
JAN 1 1961



1-1-1  
JAN 1 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6206

Item 1 Film 264 6-9-60 et

CERTIFICATE OF DEATH

06175

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN lb <b>24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>D.</b> Last <b>Carter</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1883</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>10 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handy man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Carter</b>		14. MOTHER'S MAIDEN NAME <b>Ada Jones ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Francis Carter Oakley, Maryland</b>	
17. INFORMANT <b>Francis Carter</b>		Address <b>Oakley, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage 2nd</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>ASCV Disease</b> DUE TO (c) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1960</b> to <b>May 31, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 31, 1960</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Roy L. Smith</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Mechanicsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/3/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION (City, town, or county) (State) <b>Bushwood, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingly</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Kline</b>	
25b. REGISTRAR'S SIGNATURE <b>Leonardtown, Maryland</b>		DATE <b>JUN 3 '60</b>	

STATE OF NEW YORK

6203

(M)

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MADE IN N.Y.

POST OFFICE

CONFIDENTIAL

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/87

BY SP-10

10

RECEIVED BY THE SECRETARY OF THE STATE

NOV 11 1987

NEW YORK STATE

OFFICE OF THE ATTORNEY GENERAL

ALBANY, NEW YORK

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY, NEW YORK

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY, NEW YORK

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY, NEW YORK

VS. A15ME  
5M 7/59

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
1920

FILE NO. 100000  
BIRTH NO. 100000  
IN

NAME: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]  
MOTHER'S NAME: [illegible]  
FATHER'S NAME: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]  
PLACE OF BURIAL: [illegible]  
CITY: [illegible]

STATE: [illegible]  
COUNTY: [illegible]  
TOWN: [illegible]

AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]

RELIGION: [illegible]  
MARRIAGE: [illegible]  
EDUCATION: [illegible]

OCCUPATION: [illegible]  
MILITARY SERVICE: [illegible]  
NAVY SERVICE: [illegible]

REMARKS: [illegible]  
CERTIFICATE NO. [illegible]  
MADE AT [illegible]

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FOR STATE  
HEALTH DEPT  
M

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 264 6-3-60													
MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
6221 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06177													
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oakville</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakville</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS <b>Rural</b>							
3. NAME OF DECEASED (Type or print) First <b>Delia</b> Middle <b>A.</b> Last <b>FENWICK</b>						4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 60</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11 - 25 - 1898</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>Henry Butler</b>						14. MOTHER'S MAIDEN NAME <b>Georgiana Forbes</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>						16. SOCIAL SECURITY NO. <b>-----</b>						17. INFORMANT <b>Harry L. Fenwick - RFD Mechanicsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5/20/60</b>													
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b> EXAMINER'S NAME (Type) Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>5/23/60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b> 22d. LOCATION (City, town, or country) (State) <b>Morganza, Md.</b>													
23. FUNERAL DIRECTOR <b>P.B. Robinson - Leonardtown, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>MAY 25 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>							

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1982-2-10



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06178

6222

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Mary's</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNAS HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Timothy Wayne FLOWERS</u>		4. DATE OF DEATH Month Day Year <u>May 29 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22, 1960</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Ervin FLOWERS</u>		14. MOTHER'S MAIDEN NAME <u>Honorita Faye ANDREWS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father:</u> Address <u>67 East Rennell Ave., Lexington Park, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>29 May 1960</u> , and that death occurred at <u>Station Hospital, USNAS, Patuxent River, Maryland</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Station Hospital, U. S. Naval Air Station, Patuxent River, Maryland</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>S. F. Rudolph, Jr. LT(MC) USN</u>		M.D. <u>Station Hospital</u>	
PHYSICIAN'S NAME (Type) <u>S. F. RUDOLPH, LT MC USN</u>		U. S. Naval Air Station Patuxent River, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/1/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		22d. LOCATION (City, town, or county) (State) <u>Great Mills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley Leonardtown, Maryland</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>JUN 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

8233

(5)

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REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 1, 1903

ALBANY:  
J. B. LEECH, PRINTERS,  
1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)  
15M 9/59



078

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6207

Item 8 Film 204 6-13-60 et

66179

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtowntown</b>		c. LENGTH OF STAY IN 1b <b>12hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucille</b> Middle <b>Greene</b> Last <b>May</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1913</b> <b>June ? 1911</b>
9. AGE (In years lost birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stephen Dyson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Agnes Calvery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Florence E. Lawrence Valley Lee, Maryland</b>	
17. INFORMANT <b>Florence E. Lawrence Valley Lee, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 days</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Perforated Peptic Ulcer &amp; Incarcerated Umbilical Hernia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>31 May 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>30 May 1960</b> to <b>31 May 1960</b> , that (I) (we) last saw the deceased alive on <b>31 May 1960</b> , and that death occurred at <b>3:11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ernest D. Rehman</b> M.D.		22b. DATE SIGNED <b>3 June 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ernest D. Rehman M.D.</b>		22d. ADDRESS <b>Lexington Park Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/4/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. George's</b>		23d. LOCATION (City, town, or county) (State) <b>Valley Lee, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 6 '60</b>	
ADDRESS <b>Leonardtowntown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

CERTIFICATE OF DEATH

1933



NAME OF DECEASED  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
DATE OF DEATH  
PLACE OF DEATH  
SIGNATURE OF REGISTRAR  
LOCALITY  
COUNTY  
STATE

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MAY 24 1960  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6223  
CERTIFICATE OF DEATH

06180

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Elizabeth</b> Last <b>Greenwell</b>				4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 3, 1897</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>James Robert Higgs</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Lee Dean</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs Paul Jameson Hollywood, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Hypertension</b> <b>445X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hollywood</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> 19 <b>57</b> to <b>May 20</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>May 19</b> 19 <b>60</b> , and that death occurred at <b>5AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles Greenwell</b>				22b. DATE SIGNED <b>May 24 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles Greenwell M. D.</b>				22d. ADDRESS <b>Leonardtown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/23/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		23d. LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 24 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles S. Hanks</b>	

1933

CERTIFICATE OF DEATH

1933



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George A. ...

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FOR STATE  
HEALTH DEPT.

TO THE COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
6208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06181

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Rural</b> <b>Hollywood</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>Roger</b> Last <b>Hayden</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1917</b>		9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grader Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Road</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U .S.A.</b>	
13. FATHER'S NAME <b>Francis Roger Hayden Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Gertrude Wells</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-18-5174</b>		17. INFORMANT Address <b>Teresa H. Hayden Hollywood, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Crushing injuries</b> <b>823 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>auto accident. ran off road, hit tel. pole</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>auto accident. ran off road, hit tel. pole</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>11:55</b> a.m. <b>5/12/1960</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>ROUTE 235</b>		20f. (City or town) (County) (State) <b>Laurel Grove St Marys Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W.D. Boyd</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William D. Boyd M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>5/13/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or country) (State) <b>Hollywood, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>W. Clarke Mattingley Leonardtown, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

State of Maryland

18

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MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
100 STATE STREET  
BOSTON, MASSACHUSETTS 02109

NOV 19 1964

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FOR STATE  
HEALTH DEPT.

TO THE COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
6224 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hollywood</b> d. STREET ADDRESS <b>1</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Lexington Pk.</b>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					
3. NAME OF DECEASED (Type or print) <b>Elizabeth Ann Jameson</b>			4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>19 60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1920</b>		9. AGE (In years last birthday) <b>39</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John J. Greenwell</b>			14. MOTHER'S MAIDEN NAME <b>Grace Elizabeth Higgs</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>577-26-6597</b>		17. INFORMANT <b>Paul Jameson</b> <b>Hollywood, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broken Neck</b> <b>819X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auto accident - car skidded, hit guard rail &amp; overturned</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident - car skidded, hit guard rail &amp; overturned</b>			
20c. TIME OF INJURY Month, Day, Year <b>12:05</b> e.m. <b>5/28</b> 19 <b>60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road Rt. 235</b>	
20f. (City or town) <b>Lexington Park</b>		20g. (County) <b>St. Mary's</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>William D. Boyd M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5/28/60</b>	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>	
22d. LOCATION (City, town, or country) (State) <b>Hollywood, Md.</b>		23. FUNERAL DIRECTOR ADDRESS <b>W. Clarke Mattingley Leonardtown, Maryland</b>			
24a. REC'D BY REGISTRAR <b>JUN 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			



Office of the Secretary of the Navy

Washington, D.C.

June 1, 1950

June 1, 1950

Washington, D.C.

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Auto accident

Washington, D.C.

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## 06185

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>St. Mary's</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Station Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>37 Lei Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		NAS., Patuxent River, Md.	
3. NAME OF DECEASED (Type or print) <b>Roxanne (n) LAYNE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1960</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>4-1-59</b>		9. AGE (In years lost birthday) <b>1</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant child</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elbert Aburey LAYNE</b>		14. MOTHER'S MAIDEN NAME <b>Joan Beverly CULLISON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Joan Beverly LAYNE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>493X</b> (c) <b>493X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 Hours</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Station Hospital</b>		(County) <b>NAS., Patuxent River, Md.</b>		(State) <b>Md.</b>		21. I certify that (1) (this hospital) attended the deceased from <b>4-30-1960</b> , to <b>5-1-1960</b> , that (2) (we) last saw the deceased alive on <b>1 May 1960</b> and that death occurred at <b>12:15 P.M.</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>James H. Armstrong</b> M.D.	
22b. DATE SIGNED <b>5-1-60</b>		22c. PHYSICIAN'S NAME (Type) <b>LT. J. H. ARMSTRONG, MC, USN</b>		22d. ADDRESS <b>Station Hospital</b>		22e. NAS., Patuxent River, Md.		22f. DATE SIGNED <b>5-1-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-1-60</b>		23b. DATE THEREOF <b>5/5/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Face</b>		23d. LOCATION (City, town, or county) <b>Great Mills, Maryland</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE <b>MAY 9 1960</b>	



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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some fragments are visible, such as "The following information was obtained from the records of the..."]



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Mars 6/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 6225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06183

1. PLACE OF DEATH a. COUNTY <b>ST MARY'S</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON PARK</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL, LEXINGTON PARK.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABY BOY</b> Middle <b>LUCAS</b> Last				4. DATE OF DEATH Month <b>5</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLOR</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/10/60</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEON R. HARRIS</b>				14. MOTHER'S MAIDEN NAME <b>MARY ETHEL LUCAS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MARY ETHEL LUCAS</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>736.0 SUFFOCATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>736.0</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>MINUTED</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Born in sleep drunken.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>230 5/10/60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Lexington Park St Marys Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>WILLIAM D BOYD MD</b> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Aloysius</b>		22d. LOCATION (City, town, or country) (State) <b>Leonardtown Md</b>	
23. FUNERAL DIRECTOR <b>W. C. Hattaway Leonardtown, Md</b> ADDRESS				24a. REC'D BY REGISTRAR <b>11</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

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1955 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

Decedent's Name ...

Date of Death ...

Place of Death ...

Medical History ...

Cause of Death ...

Signature of Medical Examiner ...

Signature of Coroner ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

# 1 FOR STATE HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 6227 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06184

1. PLACE OF DEATH a. COUNTY <b>St. Mary's County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HOLLYWOOD</b>		c. LENGTH OF STAY IN 1b <b>7 YEARS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HOLLYWOOD,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDITH MOORE MARSHALL</b>				4. DATE OF DEATH Month <b>May</b> 13, Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 4, 1915</b>		9. AGE (In years last birthday) <b>44 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN MOORE</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>CHARLES G. MARSHALL</b> Address <b>HOLLYWOOD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Ethanol Intoxication</b> DUE TO <b>880.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>5:00 P</b> a.m. <b>5/12/60</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>HOLLYWOOD - St. Mary's Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>Wm. J. Smith</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <b>May 13, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>SUITLAND, Md.</b>	
23. FUNERAL DIRECTOR <b>Joseph Brewer's Sons</b>				ADDRESS <b>756 PA. AVE. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 17 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	
WASHINGTON 6, D.C.							

MEDICAL CERTIFICATION

GENETIC EXAMINATION CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

06186

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood Rural</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Beatrice</b> Last <b>Mattingly</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1901</b>		9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Grant Wallace</b>				14. MOTHER'S MAIDEN NAME <b>Tose Elizabeth Redman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Albert L. Mattingly</b> Address <b>Hollywood, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>156.1</b> DUE TO <b>Acute Hepatic Coma</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. } DUE TO <b>Carcinomatosis</b> (c) <b>Carcinoma of the liver</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10.15</b> 19 <b>59</b> to <b>5.7</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>5.7</b> 19 <b>60</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. Samuels</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>A. Samuels, M.D.</b>				22d. ADDRESS <b>Leonardtwn, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		23d. LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 16 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1

[illegible]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

(M)

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VS. A15ME  
SM 2/57

Item 18 Film 264 6 3 60 ans  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD Leonardtown</b> c. LENGTH OF STAY IN 1b <b>X</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Michael A. Murray</b>		4. DATE OF DEATH Month Day Year <b>5/ 16 / 1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/ 3/ 1959</b>
9. AGE (in years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William E. Murray</b>		14. MOTHER'S MAIDEN NAME <b>June L. Brady</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Wm. E. Murray - Leonardtown, Md.</b>	
17. INFORMANT <b>Wm. E. Murray - Leonardtown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Purulent cerebrospinal meningitis</b> <b>057.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>5/16/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/19/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 23 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

2046212XV7

FOR STATE  
HEALTH DEPT.

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PROVIDER SIGNATURE

2046319x21

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.1  
6209  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07311

1. PLACE OF DEATH o. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Piney Point</b>	
3. NAME OF DECEASED (Type or print) First <b>Randall</b> Middle <b>Scott</b> Last <b>Nelson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1956</b>
9. AGE (In years lost birthday) yrs. <b>3</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Edward Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Poe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Joseph E. Nelson</b>		Address <b>Piney Point, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fibro-Cystic desase of lungs &amp; pacreas</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2days</b> <b>birth</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1960</b> to <b>June 10, 1960</b> that (I) (we) last saw the deceased alive on <b>June 10, 1960</b> , and that death occurred at <b>5P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>P. J. Bean M.D.</b>		22b. DATE SIGNED <b>6/11/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Great Mills, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/13/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. George Island Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>St. George Island, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Maryland</b>	
25a. REC'D BY REGISTRAR <b>JUN 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

CERTIFICATE OF DEATH

6808

0731

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FOR STATE HEALTH DEPT.  
Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
6230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06188									
Item 14 Film 6263 5/26/60 1wk									
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Mechanicsville</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Mechanicsville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>Jerome</b> Last <b>Spears</b>					4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>19 60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cloored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 5, 1958</b>		9. AGE (In years last birthday) <b>1</b> yrs. IF UNDER 1 YEAR Months <b>10</b> Days <b>4</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. Spear</b>					14. MOTHER'S MAIDEN NAME <b>H. Annie Dorsey</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Joseph H. Spear</b> Address <b></b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>756.2</b> DUE TO <b>acute intestinal obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Megacolon Colnital Congenital</b> (c) <b>Life</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b> <b>2 hrs.</b> <b>Life</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>W.D. Boyd</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>William D. Boyd M. D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <b>5/10/60</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		22d. LOCATION (City, town, or country) (State) <b>Leonardtown, Md.</b>			
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtown, Maryland</b>						24a. REC'D BY REGISTRAR <b>MAY 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH  
MEDICAL EXAMINER  
OFFICE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### 6210 CERTIFICATE OF DEATH

06189

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>St. Mary's</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Kenny</u> Last <u>Spence</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 11, 1960</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR <u>3</u> Months		IF UNDER 24 HRS. <u>3</u> Days		Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Andrew Spence</u>				14. MOTHER'S MAIDEN NAME <u>May Cecilia Clinton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>  </u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection Hepatitis</u> DUE TO <u>092X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cretin</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks.</u>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>25 April 1960</u> to <u>5 May 1960</u> , that (I) (we) last saw the deceased alive on <u>5 May 1960</u> , and that death occurred at <u>4 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ernest D. Rehm</u> M.D.				22b. DATE SIGNED <u>5 May 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ernest Rehm M.D.</u>				22d. ADDRESS <u>Lexington Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-6-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Peter's Church</u>		23d. LOCATION (City, town, or county) (State) <u>Ridge Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>				25a. REC'D BY REGISTRAR <u>  </u> DATE <u>MAY 16 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Road 66 2078151XV5

953

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6211

06190

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>St. George Island</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Marriot</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 28, 1878</b>			
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Henderson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lollie S. Thomas</b> Address <b>St. George Island, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 10, 1959</b> to <b>May 30, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 29, 1960</b> , and that death occurred at <b>7 A.</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>P. J. Bean</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>P. J. Bean M. D.</b>				22d. ADDRESS <b>Great Mills, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/1/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. George Episcopal Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Valley Lee, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 2 '60</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					

(M)

(I)

STATE OF TEXAS  
COUNTY OF DALLAS

1913

George W. Jones

John

George W. Jones

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George W. Jones

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George W. Jones

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George W. Jones

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George W. Jones

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George W. Jones

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George W. Jones

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George W. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6212

Item 7 Film 203 5-31-60 et

CERTIFICATE OF DEATH

06191

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>20 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Maddox</b>	
3. NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>Frank</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1875</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b> Hours <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Henry Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Quade</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mary Ellen Thomas Maddox, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 9 15</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1955</b> to <b>May 22, 1960</b> , that (I) (we) last saw the deceased alive on <b>28 May 1960</b> and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W. Clarke Mattingley</b>		22b. DATE SIGNED <b>May 26 '60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. Clarke Mattingley</b>		22d. ADDRESS <b>Mechanicville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/24/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Sacred Heart</b>		23d. LOCATION (City, town, or county) (State) <b>Morganza, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>May 26 '60</b>	
ADDRESS <b>Leonardtwn, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kumpf</b>	

CERTIFICATE OF DEATH

02333

1. Name of deceased: *Walter Hadden*  
2. Age: *30 years*  
3. Sex: *Male*  
4. Date of birth: *May 20, 1910*  
5. Place of birth: *Wallingford, Vermont*  
6. Date of death: *May 25, 1940*  
7. Place of death: *Wallingford, Vermont*  
8. Cause of death: *Heart disease*  
9. Signature of physician: *Walter Hadden*  
10. Signature of registrar: *Walter Hadden*

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*Walter Hadden*  
*Walter Hadden*  
1. Name of deceased: *Walter Hadden*  
2. Age: *30 years*  
3. Sex: *Male*  
4. Date of birth: *May 20, 1910*  
5. Place of birth: *Wallingford, Vermont*  
6. Date of death: *May 25, 1940*  
7. Place of death: *Wallingford, Vermont*  
8. Cause of death: *Heart disease*  
9. Signature of physician: *Walter Hadden*  
10. Signature of registrar: *Walter Hadden*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

6215

06192

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>White</b> Last <b>White</b>				4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 15, 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Water man</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>William W. White</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Medley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-38-7620</b>		17. INFORMANT <b>Alice White</b>		Address <b>Septland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>177X</b> DUE TO <b>Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>carcinoma (adenocarcinoma)</b> DUE TO <b>metastasis to bones</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <b>William H. Patrick M. D.</b>				22b. ADDRESS <b>Lexington Park, Maryland</b>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's</b>		23d. LOCATION (City, town, or county) (State) <b>Scotland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>				25a. REC'D BY REGISTRAR <b>JUN 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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BP

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

6215

(M)

Name of Deceased		Sex		Age	
John Doe		Male		35	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1950		New York City		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Physician		Hospital		Burial	
Dr. Smith		St. Mary's		Cemetery	
Signature		Witness		Registrar	
[Signature]		[Signature]		[Signature]	

(A person is considered to be dead when he or she has permanently lost consciousness and cannot be revived.)

Recorded

Name of Registrar		Signature of Registrar	
John Doe		[Signature]	
Date of Registration		Signature of Physician	
Jan 15, 1950		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
6231  
CERTIFICATE OF DEATH  
06193

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>S t. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Avenue</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Marshall</b> Last <b>Wise</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 13, 1882</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Water man</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Dominic Wise</b>			
14. MOTHER'S MAIDEN NAME <b>Helena Yates</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Ann Victoria Wise</b> Address <b>Avenue, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>6/6</b> <b>1959</b> to <b>5/8</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>5/4</b> <b>1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles Greenwell</b> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Charles Greenwell M. D.</b>				22d. ADDRESS <b>Leonardtown Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 10 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

# CERTIFICATE OF DEATH

1933

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Place of registration</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M-9-59

Now 6/60

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
6213 CERTIFICATE OF DEATH 06194									
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>None</b> b. COUNTY <b>St. Mary's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown, Md.</b>				c. LENGTH OF STAY IN 1b <b>30 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>					d. STREET ADDRESS <b>1 Leonardtown, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby</b>			First <b>Boy</b> Middle <b>Woodburn</b> Last			4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8, 1960</b>		9. AGE (In years lost birthday) yrs. <b>30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Creighton Woodburn</b>					14. MOTHER'S MAIDEN NAME <b>Mary Ann Burch</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>St. Mary's Hospital, Leonardtown, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Hydrocephalus</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>30 months</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 8, 1960</b> to <b>May 8, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 8, 1960</b> , and that death occurred at <b>2:45 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>P. J. Bean M. D.</b>					22b. DATE SIGNED <b>MAY 20 '60</b>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS <b>Great Mills, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael</b>		23d. LOCATION (City, town, or county) (State) <b>Ridge, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>					ADDRESS <b>Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

20 78284XV1

CERTIFICATE OF DEATH

6213

(1)  
(5)

1. Name of deceased: J. M. Ryan  
2. Sex: Male  
3. Age: 30 years

4. Date of death: May 1, 1960  
5. Place of death: Home

6. Cause of death: Heart disease  
7. Manner of death: Natural

8. Signature of physician: J. M. Ryan  
9. Signature of registrar: J. M. Ryan

10. Date of registration: May 1, 1960  
11. Place of registration: Home

12. Signature of registrar: J. M. Ryan  
13. Signature of registrar: J. M. Ryan

14. Signature of registrar: J. M. Ryan  
15. Signature of registrar: J. M. Ryan

16. Signature of registrar: J. M. Ryan  
17. Signature of registrar: J. M. Ryan

18. Signature of registrar: J. M. Ryan  
19. Signature of registrar: J. M. Ryan

20. Signature of registrar: J. M. Ryan  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

6214

06195

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>L.</b> Last <b>Woodburn</b>				4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 19, 1895</b>		9. AGE (In years lost birthday) <b>64</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				12. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		13. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
14. FATHER'S NAME <b>Daniel Woodburn</b>				15. MOTHER'S MAIDEN NAME <b>Amy L. Guy</b>			
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				17. SOCIAL SECURITY NO. <b>218 24 0567</b>		18. INFORMANT <b>Bertha S. Woodburn</b> Address <b>Park Hall, Maryland</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 3, 1960</b> to <b>May 3, 1960</b> , that (I) (we) last saw the deceased alive on <b>May 3, 1960</b> , and that death occurred at <b>03:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>P. J. Bean</b> M.D.				22b. DATE SIGNED <b>May 3, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>P. J. Bean M. D.</b>				22d. ADDRESS <b>Great Mills, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/7/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		23d. LOCATION (City, town, or county) (State) <b>Leonardtown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				25a. REC'D BY REGISTRAR <b>MAY 16 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

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CERTIFICATE OF DEATH

1914

1914

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of informant